DOCUMENT RESUME

ED 440 350 CG 030 045

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TITLE Working with Families Affected by Substance Abuse.
PUB DATE 2000-00-00
NOTE 25p.; In: Substance Abuse and Counseling; see CG 030 037.
PUB TYPE Guides - Classroom - Teacher (052) -- Guides - Non-Classroom (055) -- Information Analyses (070)
EDRS PRICE MF01/PC01 Plus Postage.
DESCRIPTORS Change; Coping; Counseling Theories; Cultural Influences; *Family Counseling; Intervention; Prevention; *Substance Abuse; Systems Approach
IDENTIFIERS Barriers to Change; Codependency

ABSTRACT

This paper focuses on assisting families who have been damaged by substance abuse and on constructive involvement of families to help all members cope. The four main topics are: (1) "Substance Abuse and Family Systems," including the effects of substance abuse on families and children; (2) "Theories and Approaches to Family Interventions," including family systems theory, stages in family counseling, main types of family therapies, and other useful approaches; (3) "Obstacles to Coping," such as codependency and other barriers which may undermine efforts in prevention and intervention; and (4) "Best Practices in Assisting and Utilizing Families in Substance Abuse Rehabilitation." Since substance abuse is a complex biocultural condition, narrowly focused linear treatment approaches are insufficient in achieving meaningful coping skills and change. Two broad treatment strategies that are recommended are prevention and intervention with family systems and family members, and involvement of family systems in intervention with their substance abusing member. Also included is a facilitator's manual which is a practical guide for teaching content through guided experiential projects. Five objectives are listed, and five student exercises are provided. (Contains 91 references and 3 tables.) (Author/MKA)

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Working with Families Affected by Substance Abuse

R. William English

Introduction

This chapter focuses on assisting families who have been damaged by substance abuse (SA) and on constructive involvement of families to help all members cope. There are four main content sections, or topics:

(1) "Substance Abuse (SA) and Family Systems," including the effects of SA on families and children;
(2) "Theories and Approaches to Family Interventions," including family systems theory, stages in family counseling, main types of family therapies, and other useful approaches;
(3) "Obstacles to Coping," such as codependency and other barriers, which may undermine efforts in prevention and intervention; and
(4) "Best Practices in Assisting and Utilizing Families in Substance Abuse Rehabilitation."

All topical areas reflect a synthesis and integration of published research. Occasionally, I contribute some thoughts from my career in counseling and rehabilitation, and from my life as a family member. The chapter ends with a brief, overview summary and references.

Substance Abuse and Family Systems

Key Definitions: Family and Substance Abuse

Definitions are important because they provide guidelines to determine what is normal or standard. Two critical definitions for this chapter are "family" and "substance abuse" (SA).

The *family* is the basic unit in society, responsible for maintaining equilibrium, or social order, and supporting the encouragement of the growth and development of its members across the life span (Freeman, 1993). The family is a united or bonded group of persons who carry out complementary roles (e.g., parent, child, friend) to discharge critical functions such as providing economic security and safety, share a common culture, share labor, create identity, transmit societal values, educate children to become responsible and independent adults, and meet intimacy or affectional needs.

Because American society is complex and rapidly changing, it is impossible to describe a typical family system. Even marriage has become an option to the creation and maintenance of families. Most family structures, however, fit into one of three types: (1) Dual Career Families, where almost 100% of men and 75% of women work (Basow, 1992); (2) Single-parent Families, usually headed by divorced women (Lewin, 1990); and (3) Remarried/Blended Families, created when two previously married partners with children remarry (Hayes & Hayes, 1991). All three types are prevalent and are viable family systems, with leaders and members who enact complementary, functional roles.

Family Systems

Families may be open or closed systems. Open family systems have flexible boundaries and a participatory communication style, where members share information, discuss, and exchange feedback. Closed family systems have rigid boundaries and a controlling communication style, which limits environmental influences to protect the family and maintain the status quo (Brown & Srebalus, 1996). McWhirter, McWhirter, McWhirter, and McWhirter (1993) believe that closed family systems are out of balance, or homeostasis, and typically demonstrate two major problems: "detachment," or exaggerated separateness, and "enmeshment," or exaggerated togetherness.

In a closed family system that is detached, members function separately and very autonomously, with little family interdependence. Family members, however, are like passing ships in the night, who communicate little or not at all, and whose social and emotional needs are often unmet. Also, boundaries in closed, detached families are so rigid that support is rarely offered unless an individual is in serious trouble or crisis (McWhirter et al., 1993).

In a closed family system that has the problem of enmeshment, the system is out of balance by too much togetherness. Interpersonal interactions in such families typically are emotionally intense and the members are

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overinvolved in and overconcerned with each others' lives. Boundaries in closed/enmeshed families are very weak, easily crossed, and poorly differentiated. This family system usually rushes to rescue a member from a stressful situation, rather than teaching constructive problem solving.

Normative growth, development, and homeostasis generally occurs the most in open-family systems that support and encourage adaptation, individuality, affection, collaboration, flexibility, and togetherness. The open family tends to be the prototype of the functional family in mainstream culture. Children are at the lowest risk of being emotionally damaged in these systems, and have the best chance to live healthy lives as adults.

In contrast, children from closed family systems are at greatest risk of being emotionally damaged and becoming less healthy adults. Children and youth from detached families often form inadequate or dysfunctional relationships outside the family because they have missed good relationships within their families of origin. Individuals most likely to drop out, run away, perhaps become homeless street persons, and develop anti-dependent attitudes are most likely to be products of detached family systems. Children and youth from enmeshed families are shackled by the family's overprotection, prone to be too dependent, and manipulate others to solve their problems. Denial, rationalization, and externalization are common behaviors of such individuals, as is passive-aggressiveness.

Family Life Cycle (Duvall, 1977; Thomas, 1992; L'Abate, Ganahl, & Hansen, 1986) refers to stages or transitions requiring adjustments in attitudes and behaviors that increase family stress and upset family equilibrium. Carter and McGoldrick (1988) reinforce the dynamic nature of each family system where the emotional process of transition and responsibilities shift through six stages:

(1) single adults leave home;
(2) couples marry;
(3) families with young children;
(4) families with adolescents;
(5) launching young adults and moving on; and
(6) families in later life.

It is common sense to recognize the many transitions that families go through and to plan ways to meet the unique challenges of parents and children at all stages of family life.

Substance Abuse is a dysfunctional condition when a person's use of alcohol or other mood-altering drugs interfere with, or have undesirable effects on, the individual's life and the lives of others (Black, 1981; Lewis, Dana, & Blevins, 1994). Clearly, there is a strong interaction between members' abuse of alcohol or drugs and family systems, which often threatens the functioning and wellness of families. Substance abuse exists on a continuum: from substance abstinence, to substance use, to substance abuse, to substance addiction. Substance abuse usually involves psychological dependency while substance addiction typically involves physical and psychological dependence (Lewis, et al., 1994).

Influence of Substance Abuse on Families

Family Effect. The association between substance abuse—especially prolonged and progressive abuse—and the quality of family life is very strong and predominantly negative. In 1983, Ackerman's research reported that more than 10 percent of children in the United States are or have been raised in alcoholic homes, but this figure was 18% in a 1999 study by the National Association or Children of Alcoholics (NACOA). This represents a substantial affected group of children of alcoholics in our society, ranging between 30 million (Ackerman, 1983) and 76 million (National Association for Children of Alcoholics, 1999). Many children of alcoholics will themselves become alcoholic, which Back (1981) estimates to be 50%.

Substance abuse usually has a pervasive effect on almost all aspects of family life, but especially in the psychological and social domains. Families become less stable because of negative emotions (e.g., stress, anger, and depression), inconsistency, neglect, abuse, and dishonesty. Substance abusers become chronic liars and family members often lie as well, as codependents and enablers. Once persons pass being moderate users of alcohol and drugs, and become psychologically and physically dependent, or both, their condition and they themselves change the family system. Problematic substance abuse usually is traumatic to a family system (Hawkins, 1998), which then drives a process of short and long-term adjustment as a defense mechanism by substance abusers and codependent family members, if use progresses to abuse and to addiction (Steinglass,

Bennett, Wolin, & Reiss, 1987).

Cecil (1985) says that denial is the chief weapon against any form of surrender to committing to recovery. Denial is a state of self-delusion that persons use to deal with pain and loss. Denial is a temporary state which may, however, continue for years or whenever persons feel safe enough to cope in other ways (Beattie, 1989). Traumatic and very stressful events (e.g., DUI arrests, failing a grade, divorce) especially may trigger a denial response, as persons shut down their awareness and acceptance of reality (Jewett, 1982).

Family responses to a substance abusing parent vary but tend to be divided into four phases, as identified by Robert Ackerman (1983), who co-founded the National Association for Children of Alcoholics. These phases are reactive, active, alternative, and unity. Families in the reactive phase are passive and constantly making adjustments to survive a stressful situation through mechanisms like denial, verbal coping (e.g., "nagging"), behavioral coping (e.g., hiding alcohol), and social, physical, and emotional disengagement/isolation.

Many families do not get out of the reactive phase, which often involves "toxic shame" (Bradshaw, 1988; Hawkins, 1998), where families often keep secrets about emotional, physical, and sexual abuse. Professional help often is needed to advance to the more functional stages of coping. "Functional" is a useful, 10-concept acronym, by Hawkins (1998), for a healthy family that can guide intervention efforts. FUNCTIONAL stands for:

- ***Freedom*** to perceive, think, emote, choose, and be creative;
- ***Unfolding*** intimacy;
- ***Negotiating*** differences;
- ***Communication***, which is clear and consistent;
- ***Trusting***;
- ***Individuality***;
- ***Open*** and flexible roles;
- ***Needs*** fulfilled for all family members;
- ***Accountability***; and
- ***Laws*** that are open and flexible.

In the second, or "active," phase, Ackerman indicates that non-abusive family members begin to grow in awareness of their own needs and wants, reduce denial, and resume some normal activities. Families in this active phase are emerging from the all-controlling dark shadow of the abuser and demonstrate greater self-efficacy.

Child Impact. Children of alcoholic (or drug-abusing) parents are at greater risk for neglect and abuse, than are so-called normal children, and are more predisposed to become substance abusers or to socialize with and marry substance abusers. Also, children from such families are at high risk for having emotional and social adjustment problems, such as aggression, hyperactivity, relationship conflicts, depression, underachievement or poor school performance, school absenteeism, and school dropout (Parish & Parish, 1983; West & Prinz, 1987).

Social immaturity, lack of self-esteem, low self-efficacy, and deficits in social skills are also common by-products of neglect and abuse. Generally, the negative impact will be greater if it lasts longer and involves multiple forms of traumas (e.g., neglect, various abuses, and divorce).

Pia Mellody (Mellody, Miller, & Miller, 1989), who describes herself as a child of abuse and a codependent, believes that emotional damage is the worst by-product of substance abuse. Feeling emotions like anger, fear, pain, guilt, and shame are framed in an unhealthy and abusive manner in dysfunctional families. While powerful emotions in functional families can be empowering, such as using fear to protect ourselves or guilt to motivate behavior change, the dysfunctional family seems to engineer disempowerment by overreacting in a negative way.

The natural characteristics, with which children are born—to be valuable, vulnerable, imperfect, dependent, immature, highly energetic, and flexible—are thwarted in dysfunctional families affected by substance abuse. Moreover, efforts at positive mentoring often are compromised by parents who overprotect or control, attack, or ignore. Mellody et al.'s (1989) work (p. 77) at a treatment center led to the belief that, when children's natural characteristics are abused, they develop dysfunctional survival traits that become core symptoms of codependence, that can cycle into a chronic illness in adult life. Table 1 shows the specific survival traits that often turn into codependency symptoms when children become adults.

Stress, chaos, and unhappiness act as motivators or triggers for persons to assume roles that will help the family and themselves to survive (Hawkins, 1998). These roles—family hero, lost child, scapegoat, or mascot—are somewhat transparent but frequently shape family interactions. The "Family Hero" is a high achiever,

perfectionistic, does what's right, and puts others first. The "Lost Child" is withdrawn, joyless, and almost invisible. The "Scapegoat," who is often the substance abuser, appears hostile and defiant but emotionally feels hurt and angry. Scapegoats attract attention through negative behavior, and a child who assumes this role is at highest risk to be a substance abuser as an adult. Finally, there is the "Mascot," a charming, affectionate family clown. This role (Wegschieder-Cruse, 1981) often is adopted by persons who lack self-efficacy and commitment. Malpique, C., Barrias, P., Morais, L., Salgado, M., Da Costa, I., and Rodriguez, M. (1998) report that families who are chemically-dependent spend at least part of their lives in a confused and chaotic atmosphere, resulting in role distortion, imbalance, and weak emotional support. There is considerable value, I believe, in assessing family systems which experience trauma in terms of their assumption of major roles. Such understanding can be the basis for making constructive changes as a family unit and as individuals.

The third, or "alternative," phase family response to a substance-abusing parent occurs when everything else seems to have failed. This is characterized by polarization, separation, satisfaction with change, and family reorganization. Since alcoholism contributes to 40% of family court cases, the security of many children is threatened by the double jeopardy of being children of alcoholics and children of divorce (Ackerman, 1983).

Families who reach the fourth, or "family unity" phase, are the most functional and are characterized by substance abstinence and growth. These families want stability, harmony, expansion, and quality—especially in relationships.

Effects on Adult Children. The effects of parental substance abuse are often traumatic and may extend well into adult life, and sometimes through the person's entire life span. In this sense, many adult children of alcoholics and other substance abusers have a post-traumatic stress disorder. Some of the most prevalent feelings and attitudes of adult children of substance abusers include hypermaturity and indecisiveness (Black, 1981); as well as lack of trust; loneliness; emotional denial; feelings of guilt, shame, and rage; sadness; uncertain identity; need for control; lack of assertion; a desperate desire to please others; and overreaction to personal criticism (Seixas & Youcha, 1985). Similarly, in *Adult Children of Alcoholics,* Woititz (1983) discusses 13 characteristics or symptoms that can pose lifelong problems, and which appear to be 20% more prevalent among adult children of alcoholics (Hager, Leerhsen, Monmaney, Namuth, & Springer, 1988). Woititz generalizes that most adult children of alcoholics:

- guess what is normal
- struggle to complete projects
- lie when it would be just as easy to tell the truth
- constantly seek approval and validation
- feel that they are different
- are super-responsible or -irresponsible
- judge themselves very harshly
- have difficulty with close relationships
- overreact to changes beyond their control
- are extremely loyal
- plunge into action without considering consequences

Maintaining balance and being moderate also seems to be a challenge for adult children of substance abusers, who are often too dependent, antidependent, needless, and wantless. Not surprisingly, such persons often have difficulty acknowledging and taking care of their own needs and wants as adults. Mellody, Miller & Miller (1989) write that "too dependent adults" spend considerable energy whining and manipulating to get someone else to meet their needs or wants, but hesitate to or will not ask because of childhood memories of abuse, when they did ask and did not receive. "Needless and wantless" adults basically have no idea that they even have needs or wants, and may even doubt that this is a basic human right (Mellody et al., 1989). Adult children of substance abusers who are too dependent are also likely to come from closed family systems that have the problem of "enmeshment." Usually, however, antidependent, needless, and wantless adult children of substance abusers come from closed families with the problem of detachment.

Cultural Influences on Families and Substance Abuse

Substance abuse is but one of many cultural influences affecting families and individuals. Quite obviously, macro systems like national society, government, ethnic and racial origin, and one's extended family are influences. Gender, genetics, and social support are examples of many more micro factors that influence families

and substance abuse. Research by Cork (1969) indicates that, where the mother is alcoholic, children have more behavioral and emotional problems.

Research on genetic or biological determinism is another systemic influence. Although studies report a higher risk for children of substance abusers to be adult abusers themselves, they also fall far short of being able to predict a child's future adjustment on the single factor of parental substance abuse (Hager et al., 1988; Miller & Jang, 1977). The inconclusiveness of consistent or convincing findings in fact underscores the resilience of offspring and supports a transactional model of human development (Werner, 1985).

Increasingly, social support is being realized as a strong influence on mediating the negative effects of substance abuse on families and individuals. Ackerman (1987), for instance, conducted research that children of alcoholics who established close surrogate relationships outside the home were much less likely to grow up to be alcoholics themselves. Millions of substance abusers and their family members also have grown and gained control and balance through peer support groups, in a seemingly ever-expanding nationwide movement.

Comprehensive coverage of cultural influences on families and substance abuse exceeds the scope of this chapter. However, cultural influences are always present and it benefits us to personalize planning and intervention that considers culture. Cultural diversity and its implications for planning and delivering services to persons recently has become a very major research priority in education and the social sciences, with strong potential for shaping more effective efforts at prevention and intervention on social problems (Freeman, 1993). An example of promising cultural aspects research is to assess persons in terms of whether their family background reflects primarily the concept of individualism or collectivism.

Theories and Approaches to Family Interventions

So far, this chapter has emphasized many negative aspects or problems associated with substance abuse, ineffective parenting, and dysfunctional families. Now we'll begin a shift to considering theoretical foundations and strategic approaches for preventing or intervening to solve these problems for families and individuals. Because substance abuse affects families and individuals in every life domain (e.g., physical, mental, social, emotional, vocational, economic, and spiritual), it should be obvious that an overall approach is called for that is comprehensive, systemic, and multidimensional. Many urgent needs and much knowledge are available to draw from, in all disciplines, whether they are broad disciplines (education, applied psychology, medicine, government, and religion, for example) or from more specialized disciplines, such as nutrition and fitness (Larson, 1992) or occupational therapy (Moyers, 1992). Having stated the need for comprehensive solutions, let us give consideration to approaches that are most suited to persons in roles such as counselors, psychologists, social workers, and various rehabilitation specialists.

Systems Theories in General

General systems theory is usually associated with the work of biologist von Bertalanffy (1968) and has led to the more focused family systems model. The main premise of this theory is that humans are living systems composed of subsystems (e.g., parents, siblings, cousins) who are connected together and dependent upon each other. This model of interdependence emphasizes that the whole system is greater than the sum of its parts (Nugent, 1994).

All living things are considered to be dynamic systems, interacting with their environments and each other. General systems theory devotes attention to the transactional process among all persons making up a system, not to specific individuals or units. The main goal in this paradigm is to maintain homeostasis (balance) or a preferred state within the system and by individuals, especially related to "power" and "control" (Brown & Srebalus, 1996).

Each family is unique in its choices of guiding principles and roles that govern its interactions. Every social problem in this scheme is a by-product of the larger family unit and not just individuals. Social units, like the family, are substantially responsible for social problems (e.g., teen violence, teen pregnancy, substance abuse) but are also most able to effectively intervene with contributions to benefit deviant individuals, balance power and control, and increase family functioning (Umbarger, 1983).

The Family Therapy Process

Family systems theory, which has evolved from general systems theory, emphasizes intervention with and by an entire family system. While many families are mostly troubled by a specific individual, the premise of

family systems theory is to intervene with everyone (Garrett, Landau, Shea, Stanton, Duncan, Baciewicz, & Brinkman-Sull, 1998). The reasoning is that all members are affected by a troubled member, all can contribute to the problem, and all are part of the problem resolution. Both open and closed family systems contribute to family functioning (Brown & Srebalus, 1996). Substance abuse or dependence acts like any stressor to disturb a family's equilibrium (Kaufman, 1985), and often becomes a primary organizing factor in the structure of the family system (Lewis et al., 1994). Terms such as "the alcoholic family," "codependence," and "enabling" reflect the demands made on families to reorganize roles, rules, and functions caused by substance abuse (Steinglass, P., Bennett, L. A., Wolin, S. J., & Reiss, 1987).

Family counseling is one of the most important intervention strategies used to challenge substance abuse. The process components for family counseling are adapted from individual counseling and consist of assessment, goal setting, treatment plan development, implementation, and termination. The assessment phase of family counseling is used like a window, to see how the family functions, deals with stress, communicates interpersonally, solves problems, and interacts with the outside world.

For instance, the assessment of family function, often through observing them in action, may reveal triangular relationships, where two family members align themselves to oppose another family member (Bowen, 1978). The implementation phase of family counseling is used for change. Counselors model and train effective communication skills, such as active listening. They contribute by guiding conflict resolution and problem solving while being supportive of all family members, but notably persons who are confronting a problem and need extra support (Brown & Srebalus, 1996). Reframing interactional patterns and realities is used as a technique to redefine problems in a more acceptable manner and reduce defensiveness (Watzlawick, Weakland, & Fisch, 1974). The complexity of working with a somewhat dysfunctional family group demands that counselors be managers or coordinators. Sometimes, familial tension, anger, and conflict require counselors to be referees, allies, or advocates.

The termination phase brings family counseling to a close while building bridges to maintaining goal achievement. Since family systems are dynamic, members need to be instructed to have a developmental perspective about the growth challenges to family members of different ages and how the family life cycle calls for numerous transitions over time (Carter & McGoldrick, 1980).

Stages in Family Counseling

Family needs differ at various stages of recovery and healing. Various theorists suggest somewhat different looks at layers in stage composition, but all who write about family counseling believe in a continuum of stages or care from beginning to end of treatment.

The following similar processes, for instance, have been postulated by several family specialists as four predictable stages in family counseling (Brock & Barnard, 1988; Hershenson & Power, 1987; Perez, 1979):

I. *Initial Stage:* Developing a relationship and assessing family problems.
II. *Middle Stage:* Achieving emotional awareness and acceptance of dysfunctional family patterns.
III. *Last Stage:* Helping the family to learn how to change their systems.
IV. *Termination:* Helping the family separate from therapy and continue with other supports.

Several theorists also have postulated somewhat related phases or stages for family coping and family intervention where substance abuse is a critical problem. Ackerman (1983) writes that family response to alcoholism can be divided into reactive, active, alternate, and family unity phases. Ackerman cautions that not all families will progress through phases, and states that many remain in the first phase and do not get beyond family denial and inadequate coping, nor move further into social disengagement.

The model of Bepko and Krestan (1985), for instance, defines three stages in intervention:

(1) attainment of sobriety;
(2) adjustment to sobriety; and
(3) long-term maintenance of sobriety.

Schlesinger and Horberg (1988) believe that the recovery process is a journey through three regions: exasperation, effort, and empowerment. In the beginning region of "exasperation," individuals feel emotionally overwhelmed and out of control; family life reflects chaos, shame, and helplessness. In the middle region of "effort," members of families begin to realize the chance of a better life and perceive a release from chaos. Families who reach and complete the final stage of "empowerment" begin to believe in their own competence, or self-efficacy, and perceive that their dreams may come true. Feelings of safety, respect, pride, and trust (which are very threatened in region one) increase substantially for families that progress through region three.

Table 1. **The Effect of Dysfunctional Parenting on the Natural Characteristics of a Child**

Natural Characteristics of a Child . . .	*when abused become . . .* **Dysfunctional Survival Traits . . .**	*that become . . .* **Core Systems of Codependence**
Valuable	Less-than or Better-than	Difficulty experiencing appropriate levels of self-esteem
Vulnerable	Too vulnerable or Too Good/Perfect	Difficulty setting functional boundaries
Imperfect	Bad/Rebellious or Invulnerable	Difficulty owning and expressing one's own reality and imperfection
Dependent: needing, wanting	Too dependent or Antidependent Needless/Wantless	Difficulty taking care of one's adult needs and wants
Immature	Extremely Immature (Chaotic) or Overmature (Controlling)	Difficulty experiencing and expressing one's reality moderately

Another model for families affected by alcoholism (Usher, 1991) separates recovery into four sequential phases:

(1) "treatment initiation," where the counselor makes clinical assessments and guides the family in treatment;
(2) "learning," where the family acquires new coping skills to use after alcohol is removed from the family system;
(3) "reorganization," where the therapist evaluates the family's ability to maintain abstinence and facilitates the healing process; and
(4) "consolidation," where the alcoholic member is securely abstinent, permitting the family to reorganize in a system featuring intimacy and affirmation.

All of these models of family counseling, where there is trauma from substance abuse, share the common belief that recovery is a process, not a final event. Also, they all embrace the assumption that most family systems have the resources to recover and recognize themselves to be healthy units. All of these models also warn that ability to constructively change systems is strongly associated with the degree of readiness to change.

Lewis (1992) has created yet another model for family counseling that is claimed to reconcile the others. This so-called "overarching" approach emphasizes three stages:

(1) interrupting ongoing patterns,
(2) facing the reality of change, and
(3) deepening and maintaining change.

When treatment starts, the counselor assists family members to interrupt negative patterns, which have previously characterized their dysfunctional family system, through the alternatives of confrontation or disengagement. The desired outcome of confrontation is that the substance abuser takes ownership of having a problem that needs treatment. Disengagement occurs when family members need to initiate the change process without the participation of the substance abuser. Schlesinger and Horberg (1988) believe that the disengagement process can interrupt rigid patterns of interaction, provide stability by redefining boundaries, and help family members to move away from the codependency feature of taking responsibility for others' behavior. In somewhat

similar fashion, Ackerman (1983) suggests that disengagement can help family members change or shift from a "reactive" (passive mode) to an "active" (assertive) style.

In the second stage, according to Lewis (1992), family members face another major adjustment related to dealing with problems and each other without the use of substances. While this may not seem to be a major problem, Lewis believes it is actually a crisis situation because families have been living everyday lives based on transactional patterns involving alcohol or drug abuse, and they have not learned adequate problem-solving or conflict resolution skills. Sometimes, families resolve the crisis successfully, but many families react to the crisis pressure by separation or divorce, and some try to re-establish the warped homeostasis of substance abuse that they have so long known (Usher, Jay, & Glass, 1982).

Counselors can be extremely helpful to families by assisting them to understand that the exodus from the chaos of substance abuse may be replaced by a different crisis, calling for different roles and different skills (Lewis, Dana, & Blevins, 1994). During this period of time, the family needs to be helped to weather the new crisis situation by focusing on such short-term goals as keeping the family system calm, reducing conflicts, and encouraging individual members to meet their own needs. Also, the family's concerns about possible substance relapse should be addressed within the context of making minor structural changes to give them time to adjust (Bepko & Krestan, 1985).

In the third and last stage of the overarching model by Lewis (1992), the focus is on deepening and maintaining change. Emphasis is placed on achieving realistic hopes, continual improvement in assertiveness, problem solving and negotiation skills, and on empowerment. The responsibilities of the counselor during the phase of deepening and maintaining change are to be a great parent figure and assist by being a barometer of reality, by educating and modeling effective behaviors (Ackerman, 1983).

Six Main Types of Family Counseling

Like all other counseling approaches, family counseling reflects divergent viewpoints. These views are shown in the writings and teachings of prominent therapists and educators. Six of the most prominent theories are:

(1) Psychodynamic Family Therapy;
(2) Experiential/ Humanistic Counseling;
(3) Bowenial Therapy;
(4) Structural Therapy;
(5) Communication Theory; and
(6) Behavioral Intervention.

Each of these perspectives is built around the idea that individuals who are troubled effect and are affected by their family units. Each approach examines the development of the individual in a social context (Lewis, Dana, & Blevins, 1994).

Family dynamics and development related to general systems theory can be applied to substance abuse treatment through a variety of family approaches. Family therapists, regardless of theoretical orientation, address current problematic family dynamics, explore relationships and conflicts within the family, and consider the effects of these dynamics/conflicts on the whole family, as well as individuals. In general, family therapists tend to be very active in sessions and often act as instructors, coordinators, and guide in reorganizing families to have more constructive patterns of interaction (Nugent, 1994).

One very useful and frequently referenced categorization of family therapy is provided by Goldenberg and Goldenberg (1985), who described six types of family therapy on eight criteria:

1. Major time frame
2. Role of unconscious processes
3. Insight vs. action
4. Role of the therapist
5. Unit of study
6. Major theoretical underpinnings
7. Major theorists and practitioners
8. Goals of treatment

Table 2, which follows, replicates the Goldenbergs' (pp. 152-153) comparison on three of these critical criteria.

Table 2: A Comparison of Three Theoretical Viewpoints in Family Therapy

Dimension	Psychodynamic	Experiential / Humanistic	Bowenian	Structural	Communication	Behavioral
1. Role of Therapist	Neutral, makes interpretations of individual and family problems	Active facilitator of potential for growth, provides family with new experiences	Direct but non-confrontational, detriangulated from family fusion	Stage Director manipulates family structure in order to change dysfunctional sets	Active, manipulative problem-focused, prescriptive, paradoxical	Directive, teacher, trainer or model of desired behavior, contract negotiator
2. Major theorists and practitioners	Ackerman, Framo Boszormenyi-Nagy, Stierlin, Skinner, Bell	Whitaker, Kempler, Satir	Bowen	Minuchin	Jackson, Erickson, Haley Madanes, Selvini-Palazzoli	Patterson, Stuart, Liberman, Jacobson, Margolin
3. Goals of treatment	Insight, psychosexual maturity, strengthening of ego functioning, reduction in interlocking pathologies, more satisfying object relations	Growth, more fulfilling interaction patterns, clearer communication; expanded awareness, authenticity	Maximization of self-differentiation for each family member	Change in relationship context in order to restructure family organization and change dysfunctional transactional patterns	Change dysfunctional, redundant behavioral sequences ("games") between family members in order to eliminate presenting problem or symptom	Change in behavioral consequences between persons leads to elimination of maladaptive or problematic behavior

Source: From Substance Abuse Counseling, An Individualized Approach (2nd ed.), by J.A. Lewis, R.Q. Dana, and G. A. Blevins, pp. 152-153. Pacific Grove, CA. Brooks/Cole Publishing Co.

Readers of this chapter are encouraged to study these and other major theories and therapies in depth, and to do so through original resources by the leaders of various approaches. Additional reading will go far to increase the very brief comments that follow regarding six of the main family therapy strategies.

Psychodynamic Family Therapy. This approach, which is based on psychoanalytic thought, emphasizes the effects of individual deviance/pathology on the family system. It views the family as a group of interlocking personalities; and indicates that insight is important for change. Nathan Ackerman (1981), one of the early pioneers of family therapy, recommends that therapists develop a close bond with family members and use the power of that relationship, as well as their expertise, to counteract defenses and convert dormant conflicts into open, interpersonal encounters. The therapist in this scheme is a benign authority figure, or "great parent figure."

Experiential/Humanistic Therapy. The career of Virginia Satir (1967, 1972) might be associated with communication theorists, but Goldenberg and Goldenberg identify her as a leader of experiential/humanist therapy. Family counseling, as practiced by Satir, focuses on everyday communications of specific families. Among the dysfunctional communication styles that Satir has identified are those of placator, blamer, and super-reasonable person. Therapy tries to move families away from dysfunctional patterns, toward congruent, flexible, and open transmission.

Bowenian Family Therapy. "Differentiation of self" is the cornerstone concept of the family therapy system developed by Murray Bowen. This concept "defines people according to the degree of fusion or differentiation between emotional and intellectual functioning. This characteristic is so universal that it can be used as a way of categorizing all people on a single continuum." (Bowen, 1982).

People at the lowest end of this continuum are less flexible, less adaptable, and less emotionally dependent. At the other extreme are individuals and families who are more flexible, more adaptable, and more independent of the emotionality of those around them.

Another central concept to Bowen (1982) is "multigenerational" transmission of problems, such as marital conflict, dysfunction in one spouse, or projecting blame onto children. One other key notion is that of "triangulation," where two parts of a family form an adversarial alliance to combat another part (e.g., one parent and children versus the other parent).

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Counselors using Bowenian therapy focus on increasing family balance by recognizing multigenerational patterns of behavior (e.g., punishing others through silence or glares), modifying the central family triangle, and encouraging the process of differentiation. The anticipated outcomes of this therapeutic process is increased individuality and identity of each family member and, therefore, increased health of the whole family (Bowen, 1982).

Structural Family Therapy. Salvador Minuchin (1974, 1979, 1993) is the creator of structural family therapy, which is a well-known, systems-oriented approach. Therapists using this strategy must engage the family in interactive activities, where they can objectively observe and assess "enduring interactional patterns that serve to arrange or organize a family's component subunits into somewhat constant relationships" (Umbarger, 1983, p. 13).

The process of change begins as the counselor gains information to understand family dynamics and family structure. Subsequently, the counselor gradually confronts the family's perceived reality and shifts focus from the individual symptom bearer (e.g., substance abuser) to the whole family system. The main outcome goal of this therapy is to "change the structure of the family system, making it more functional in its own environmental context" (Lewis, Dana, & Blevins, 1994, p. 157).

The Communication Model. Much of the pioneering work on the communication model, which also was created from a systems perspective, was begun in the 1950s by Gregory Bateson and an interdisciplinary team that was to become the Mental Research Institute (Lewis, Dana, & Blevins, 1994).

> Bateson's work was instrumental in shifting the focus of family therapy from the single individual to the exchange of information and the process of evolving relationships between and among family members. It was also Bateson who stressed the limitations of linear thinking in regard to living systems. . . . He called instead for an epistemological shift — to new units of analysis, to a focus on the ongoing process, and to the use of a new descriptive language that emphasizes relationships, feedback information, and circularity" (Goldenberg & Goldenberg, 1985, p. 6).

Application of the communication model is probably best exemplified by the strategic therapy of Haley (1976) and Madanes (1981), who emphasized active methods for changing repetitive communication patterns between family members, and for negotiating solutions to solvable problems. After agreeing on one or several solvable problems, the therapist uses directives for families to follow throughout treatment. An example is the paradoxical directive "where a therapist actually prescribes that a family member continue in a behavior (e.g., cynicism) that would be expected to be targeted for change" (Lewis, Dana, & Blevins, 1994, p. 158).

Behavioral Family Therapy. Liberman (1981) and other behavioral therapists see the family as a "system of interlocking, reciprocal behavior" (p. 153). Counselors using the behavioral family therapy of approach find ways to reinforce new, positive, adaptive behaviors to substitute for undesirable actions. Drinking water, coffee, or tea might substitute as a social aid for liquor; or use of a worry stone to rub might be reinforced over use of cigarettes. Modeling effective behavior, where learners can carefully observe positive behavior, is an important role for counselors using this approach.

Liberman (1981) and other family counselors using social learning approaches focus on specific measurable behaviors and on the environmental contingencies that tend to develop and maintain them. Concrete goals are established by altering the patterns of reinforcement (e.g., talking versus yelling) with the models provided by the social unit (e.g., time out versus punishing silences).

Teaching and training by a therapist leader also is very important to behaviorists, who believe that the description, demonstration, and guidance/supervision of learners contributes to increased competence and confidence. Examples of such training include high attending skills (e.g., eye contact), techniques for managing stress (e.g., time management or negotiation), and self-controlled methods to change behavior (e.g., relaxation exercises and reframing).

Synthesizing Differing Family Therapies

Various approaches to family therapy represent an A to Z continuum, to which a theoretical orientation emphasizes the individual or the family system. Position A therapists, like Ackerman (1983, 1987), focus on

the individual's psychodynamics; and position Z therapists focus entirely on the family system as the unit for both pathology and change. The behaviorally disposed position Z therapists are much more likely to infer that traditional psychiatric problems are societal and interpersonal symptoms of maladaptive family functioning (Kolevzon & Green, 1985). Within this model, the therapist guides reality testing, educates, and models skills and situationally appropriate behavior.

Some valuable integration of somewhat different major therapy approaches comes from Freeman (1993), who states that there are five general implications about family treatment that apply to all family system approaches. One universal implication is that a robust combination of modalities can be applied to individual, couple, family, and group sessions (Watzlawick, Weakland, & Fisch, 1974). A second implication is that, in some instances, it is best to attempt keeping the family unit together but at other times it may be best to help family members separate, complete closure, and adapt to new family relationships (Janzen & Harris, 1986). A third implication that overarches all theoretical and therapy approaches, is to invest further in prevention and pretreatment resources. This particularly makes sense when the problematic family member is not yet into actual substance abuse, or abuse is at an acute stage, and when offspring are children.

A fourth implication is that systems theory helps predict the risk potential when natural developmental transitions occur in families, such as teenagers who need to establish unique identities and have intimate relationships (Erickson, 1985). Finally, a fifth implication is that special adaptations of these approaches often may be needed. This range of choices includes multiply addicted family systems, ethnic and minority families, blending family groups, couples, single-parent families, and same-gender families. With rare exception(s), only a few of these approaches have been put into practice to address ethnic issues in families, which is a weakness to correct (Boyd-Franklin, 1989).

Systems Approaches Especially Applicable to Substance Abuse

Table 3, presents a comparison of four family systems approaches that Freeman (1993, p. 7) thinks are well suited in substance abuse treatment. These strategies—communications, task-centered, structural, and problem-solving—are best described by four focusing dimensions or criteria:

(1) related to problems in general;
(2) substance abuse problems;
(3) treatment goals; and
(4) principal treatment strategies.

These same criteria have been used as well by Freeman to describe family therapy that mainly focuses intergenerationally or strategically.

Common denominators exist for all family systems' theoretical applications, such as: elimination of substance abuse from the family system and reduction of family stressors that could trigger a relapse, and increase in the system's ability to nurture and support members. In addition, Freeman (1993) believes that all family systems approaches emphasize common treatment strategies such as homework assignments, joining functional groups (e.g., a choral group), and objectifying the family system.

Communication, structural, and problem-solving approaches have been previously described. However, it is worthwhile to explain that the focus of task-centered groups is to model, teach, and train so that consumers have greater self-efficacy and competence to perform skills. An example might be to teach parents to use "I" statements and warm body language when they wish to listen actively and negotiate with their teenage children. Psychosocial educational training (e.g., discipline) and parent education are increasingly conducted as task-centered groups (McWhirter, et al., 1993). Social support groups such as AA and Al-Anon (Williams & Swift, 1992) illustrate task-centered groups that are effective at developing and maintaining change to curb substance abuse and improve family functioning. The Circles of Support or person centered planning approach, which began in special education, seems to have great potential to transfer to mobilizing natural supports, to assist focus persons and families affected by substance abuse (Perske, 1998; Snow, 1989).

Table 3. **A Comparison of Family Systems Approaches in Substance Abuse Treaments**

Dimensions of Each Approach	Intergenerational	Strategic
Focus related to problems in general.	Family-of-origin prescriptions, proscriptions, ghosts, secrets, anniversary dates that affect behavior of current family negatively	Family resistances to changes, belief systems assumptions, and demands that lead to impasses among the members
Focus related to substance abuse problems	Family projection process involving addictions in the previous generations, fears of intimacy, and family secrets that enable substance abuse and codependency	False assumptions of the members about the role/ consequences of substance abuse manifested in denial, utopias, demands that members sould be respon sible for each other's happiness
Goals of treatment	Address/resolve unfinished family business and cutoffs from previous generations that can prevent recovery	Resolve family impasses, change family's basic premises/assumptions that enable the addiction, make covert aspects of the family's process overt.
Principal treatment stratgies	Construction of the family genogram and analysis; reenactment; contacts with family of origin to address unfinished business	Paradoxical directives or second-order change(re-framing, symptom pre-scriptiom, using resistance); circular questions; scaling techniques
Chapter(s) in which approach is described in this book	8 and 9	9

Source: From *Substance Abuse Treatment: A Family Systems Perspective*, by Edith M. Freeman, p. 8. Newbury Park, CA: SAGE Publications.

Obstacles to Coping with Substance Abuse

Barriers exist for almost every challenging accomplishment in life. Coping with substance abuse certainly represents a large challenge for family systems and individuals. The value to having a real grip on real problems and coping strategies is that it sets the stage for significant personal growth. Codependency by significant others is the biggest barrier to coping and will receive the majority of focus in this chapter. Other obstacles to be briefly described include:

- Irrational fears
- Unresolved interpersonal conflicts
- Closed, linear approaches
- High stress and/or anger
- Shame and guilt
- Poor time and organizational skills
- Low self-efficacy
- Non-mainstreamed cultures
- Poor social skills
- Dual diagnoses
- Weak social support

Codependence

The barrier of codependence is part of the notion of family interdependence, and the idea that one member's problem(s) represent a problem in the total family system (Nugent, 1994). When substance use moves to levels of abuse and addiction, families lose their balance (homeostasis) that increases demands on family members to assume responsibilities for the abusive or addicted family members. In circumstances where family boundaries are unclear, members are enmeshed and authentic communication is infrequent. Instead, members often engage in false intimacy. There is a substantial undertow which can pull healthy family members down and compromise them to assume various compensating roles to regain balance.

One such role is that of an "enabler" (Miller, 1988; Williams & Swift, 1992), which usually occurs when a spouse or adult partner covers up the abuse and assumes many of the user's responsibilities. Quite frequently, the enabler also self-identifies and is considered by others to be a martyr (Hogg & Frank, 1992; Schaef, 1986). Children in highly compromised families, because of alcohol or drug abuse, assume complementary roles to help themselves, as well as the family, survive emotional stress while maintaining secrecy, denial, and "face saving." One child may act as the "hero," who achieves success and redeems the family; another may contribute levity as the family clown/ mascot; another may share the responsible role of "enabler;" one may become an invisible "lost child;" and others may act out family problems in the role of "scapegoat" (Ackerman, 1987).

Codependence is defined by Wegscheider-Cruse (1985) as an addition to a relationship that stifles self-growth and self-expression and which closely resembles a person's addiction to alcohol or drugs. In a codependent family, members have not developed their own independence and, consequently, believe that they cannot express their own needs, wants, and feelings (Nugent, 1994). Wegscheider-Cruse (1985) sees codependence as extreme dependence on a person that ultimately becomes a dysfunctional relationship and impacts upon all other close relationships. Subby (1987) views codependence as caused by prolonged exposure to oppressive, closed-family rules that stifle open expression and straightforward discussion of personal problems and problem solving. Hawkins (1998) states that codepency occurs when persons repress their self-awareness or do not get their needs met.

Cermak (1986) believes that codependence reflects exaggerated self-control and control of others, enacted as a maladaptive way to reduce free-floating anxiety or shame (Fossum & Mason, 1986; Subby, 1987). Shame, in fact, is a major cause of codependency, since codependent individuals usually grow up in shame-based family environments and have gained little sense of self or identity.

A family system characterized by codependence has one or more persons who contribute to substance abuse and family disorganization as an "enabler." Miller (1988), in a book called *The Enabler,* offers a definition: ". . . the person who supports someone who is capable of standing on his or her own is an enabler." Miller believes that enabling is a learned role and that enablers work at being virtuous and righteous. The enabler's many virtues, to Miller, include sacrifice, tolerance, acceptance, working hard, capable, courageous, tough, forgiving, wise, and loving (Miller, 1988).

A number of common behaviors are believed to be typical of codependence and are described in a variety of resources (Beattie, 1989; Cermak, 1986; Freeman, 1993; Hogg & Frank, 1992; Mellody, Miller, & Miller, 1989; Subby, 1987; Wegscheider-Cruse, 1985). Typical codependent behaviors include:

(1) Martyrdom: giving up one's own needs in order to meet the needs of others;
(2) Fusion: losing one's identify in an intimate relationship;
(3) Intrusion: controlling the behavior of intimates through excessive caretaking, guilt, or manipulation;
(4) Perfection: holding unrealistic expectations of oneself and others; and
(5) Addiction: using compulsive behaviors to manage one's emotions.

Entire books have been written on the topic of codependence. Beattie (1987, 1989), who is a professional as well as a codependent, has authored two such insightful books. Mellody, et al. (1989) have written another, *Facing Codependence,* which partially emphasizes the lead author's background as a codependent.

The oppressive rules that Subby (1987) believes undermine families and move them to become dysfunctional are silent messages such as: "Don't feel or talk about feeling," "Don't identify, talk about, or solve problems," "Don't be who you are—be good, right, strong, and perfect," "Don't be selfish—take care of others and neglect yourself," "Don't have fun," "Don't trust other people or yourself," "Don't be vulnerable," "Don't be direct," "Don't get close to other people," and "Don't grow, change, or in any way rock this family's boat." (Beattie, 1989, p. 16).

Beattie, in *Codependent No More* (1987) and *Beyond Codependency* (1989) indicates that, in her own experience, oppressive rules were sometimes stated and sometimes sensed but not stated. She concludes that "co-dependency is about the ways we have been affected by other people and our pasts," which can result in damaging other messages like "I'm not lovable," "I don't deserve good things," and "I'll never succeed." (Cermak, 1986; Beattie, 1987, 1989; and Mellody, 1989).

Various authors (Cermak, 1986; Beattie, 1987, 1989; and Mellody, 1989) write that the trauma affecting many children related to substance abuse carries on and affects them as adults. Beattie and Mellody actually believe that codependence is a disease in its own right, and Cermak (1986) believes it is a form of post-traumatic stress disorder. Cermak indicates that "the symptoms of stress disorder in co-dependency are similar to the symptoms of stress disorder in war veterans." Beattie (1989) states that "codependent feelings and behaviors—fear, anxiety, shame, an overwhelming need for control, neglecting ourselves, and focusing on others—may suddenly emerge when something in our current environment reminds us of something noxious."

Cermak (1986) concluded that the two pervasive symptoms of codependence as a stress disorder are "psychic numbing," where persons freeze their emotions to survive; and "hypervigilance," where persons try to be comfortable by continually monitoring their surroundings. Mellody, Miller, and Miller (1989, p. 4) decided that there are five core symptoms where codependents have difficulty:

1. Experiencing appropriate levels of self-esteem;
2. setting functional boundaries;
3. owning and expressing their own reality;
4. taking care of their own adult needs and wants; and
5. experiencing and expressing their reality moderately (p. 4).

Readers are referred to their book on *Facing Codependence* for an in-depth description.

While codependence is viewed as the biggest barrier to prevention and recovery from substance abuse, it is a treatable condition. Metzger (1988) and Nace (1987) make two helpful suggestions for treatment. First, they indicate that the goals of treatment of partners and families should be to work through their own problems and attitudes, in order to gain sufficient functional separateness or independence to substitute for dysfunctional roles involving exaggerated control, management, or manipulation. Second, Metzger (1988) and Nace (1987) state that intervention will be more successful if family members can overcome the tendency to blame the recovering substance abuser and curb strong negative emotions, such as rage and resentment.

Other Obstacles to Prevention and Recovery

Brief statements follow about other barriers that deserve consideration as part of the effort to prevent substance abuse and to guide rehabilitation efforts.

Irrational Fears. Persons affected by substance abuse often have fears that are excessive; strong, negative emotions like anxiety, panic attacks, shame, guilt, and blame. Sometimes, irrational fears take on a life of their own and increase damage to lives (Beattie, 1989; Mellody, 1989). Cognitive-behavioral therapies appear to be the best antidote to reducing or eliminating irrational fears.

Closed, Linear Intervention Approaches. Substance abusers and their families have multiple needs and will benefit the most from a variety of complementary interventions (Stocker, 1998). The disease model of alcohol and drug addiction is especially restrictive in its narrow focus, rules, and authoritarian insistence that the Twelve-Step model is "the only way" to recovery (Lewis, Dana, & Blevins, 1994). Increasingly, experts are recommending a blended approach, such as the Transtheoretical Model for behavior change, which encourages counselors to provide the appropriate treatment techniques (process) at the appropriate time (stage) (Lam, Hilburger, Kornbleuth, Jenkins, Brown, & Racenstein, 1996).

Shame and Guilt. Nugent (1994) believes that Fossum and Mason (1986) made a major contribution to the treatment of alcoholics and codependents by focusing on the dynamics of guilt and shame, and the difference between them. Guilt involves admitting an inappropriate or destructive behavior and correcting it, which raises self-esteem. In contrast, shame is far more damaging because it is a feeling that one is basically bad, unworthy, or inadequate (Hawkins, 1998). Shame is created and reinforced in alcoholic families so that children carry

these feelings into adult relationships. Such adults especially find it difficult to establish intimate or close interpersonal relationships (Ackerman, 1983; Black 1981; Fossum & Mason, 1986).

Low Self-Efficacy. Trauma from substance abuse, including shame, often has a lasting, negative impact on self-esteem and self-efficacy. Achievement obviously is compromised when persons believe that they are unworthy (Fossum & Mason, 1986) or feel inadequate and lack confidence to perform successfully (Cermak, 1986). Children reared in homes emphasizing negative relationships, such as "I'm OK—you're not OK" (Harris, 1969) and prescriptions to "don't talk, don't trust, and don't feel" (Black, 1981) are likely to carry their doubts and indecisiveness into adult life and periodic post-traumatic stress (Beattie, 1989).

Weak Social Support. Most external validation of one's worth comes from the support and encouragement of significant others and natural supports. However, the traumatic impact of substance abuse on families and children usually leads to a dysfunctional family that is isolated and uncommunicative with each other and with outsiders. Disempowerment replaces empowerment and generally denies or lowers the quality and quantity of support for emotional, mental, leisure, and daily living activities (Beattie, 1989; Rubin, 1993; Bennett, Wolin, & Reiss, 1987; Black, 1981).

Inadequate Social Skills. Listening, providing feedback, being appropriate, self-disclosing, identity and self-awareness, expressing feelings verbally and nonverbally, assertiveness, problem solving, and conflict-management negotiation are social skills that contribute greatly to social support (Johnson, 1996). Persons with strong social skills tend to have a constructive social support system, and persons with weak social skills usually have weaker social support, often full of conflict in relationships.

Lewis, Dana, and Blevins (1994) indicate that interpersonal skills training are very important to treatment of people with substance dependency problems, by providing a means for coping with high-risk situations and obtaining more social support. Assertiveness training, including teaching refusal skills, is especially effective in helping persons effected by substance abuse (Goldstein, Reagles, & Amann, 1990).

Unresolved Interpersonal Conflicts. People are often impeded by their unwillingness or inability to resolve conflicts. Beattie (1989) writes that "difficulty dealing with feelings, especially anger, can limit our negotiating skills. The issue may switch from 'How can I solve this problem?' to 'What can I do to punish you for making me angry?'" (p. 191). Thus, some persons are led into interpersonal conflict by their embarrassing mistakes and inadequate social skills. Negotiating is particularly recommended as a strategy for reducing or resolving conflicts (Beattie, 1989; Johnson, 1996).

High Stress and Anger. Some stress and anger can be motivating and productive, but too much is destructive to individuals and family systems. Various approaches to help reduce stress and anger include relaxation training (Jacobsen, 1968); modeling positive communication skills, such as eye contact, posture, and refusal of substances (Miller, 1988; Upper & Cantela, 1979); contingency contracting (Goldstein, Reagles, & Amann, 1990); systematic desensitization (Lewis, et al., 1994); and social skills training (Johnson, 1996).

Non-mainstream Culture. Ethnic cultures may normalize substance abuse and reinforce resisting intervention. Awareness of verbal and nonverbal communication patterns and taking time to create an informal atmosphere is essential to building trust (McRoy, Sharkey, & Garcia, 1985). Many families may have a strong, cultural paranoia because of dissatisfying previous interaction experiences with professionals (Boyd-Franklin, 1989). Quite clearly, a need exists for selecting and training counselors who are culturally sensitive to the wants and needs of minorities (Brown & Srebalus, 1996, pp. 163-186).

Dual Diagnosis. This term usually refers to the co-occurrence of substance abuse and mental disorders. Penick, Nickel, Cantrell, Powell, Read, and Thomas (1990) reviewed the research literature and concluded that between 30% and 70% of persons with substance abuse problems also had at least one additional mental disorder, such as depression or personality disorder. Persons with substantial physical disabilities and a substance abuse problem also have a dual diagnosis. Two or more diagnostic conditions obviously increase the risk to individuals and families, and represent greater challenge to coping.

Summary and Best Practices in Working with Families

Substance abuse (SA) is a major stressor that has profound and primarily negative effects on family systems as well as on individual abusers. As substance use progresses from use to abuse, and possibly to addiction, families usually change to adjust roles, activities, and relationships. A family's struggle to maintain balance or homeostasis is a huge challenge. Family members and even entire family systems often become codependent and assume roles such as the "enabler."

Strategies to cope with substance abuse must be multifaceted and viewed as lifelong processes to maximize the wellness of individuals and family systems. Many, if not most, individuals and families affected by substance abuse are better off by adopting the attitude that they have a chronic condition, similar to epilepsy or diabetes, which requires paying attention to prevention and intervention throughout life, much like a daily medicine. Many of the logical best practices for prevention and intervention are implied or identified in earlier parts of this chapter. All of the obstacles that were just listed are examples of intervention practices.

Since substance abuse is a complex biocultural condition, with substantial intergenerational connections and high recidivism, it is clear that narrowly focused linear treatment approaches will be insufficient in achieving meaningful coping skills and change (Stocker, 1998). This leads me to recommend two broad treatment, or intervention, strategies:

(1) prevention and intervention with family systems and family members, and

(2) involvement of family systems in intervention with their substance abusing member.

Regarding the broad strategy of prevention and intervention with family members and family systems, there should be a continual focus on homeostasis and wellness. Observational assessment of the family in action and a type of family systems group therapy will go far toward improving balance, functionality, and opening up closed systems. Some focus on intergenerational assessment and intervention also may be very useful. In some instances, as with many codependent enablers, individual counseling may be helpful. Training—involving description, modeling, and practice—can be utilized to build a variety of critical coping skills to improve communications, build relationships, reduce stress, reduce anger, and negotiate conflicts.

Social support has been consistently shown to improve family systems, and efforts will be justified if they strengthen the existing family and enhance external support through the extended family, peer supports within the substance abuse arena (such as Al-Anon), and natural supports that evolve from everyday activities (e.g., bowling team, choir, investment club, etc.). Social support networks, especially natural supports who truly care about dependent individuals and their families, can almost always be strengthened, and old supports can be blended with new persons. One very promising approach to consider is building a Circle of Support for an individual or family to meet periodically and collaborate to help realize desired futures (Mount, 1990; Mount & Zwernik, 1988; Perske, 1998; Snow, 1989; Thomas, Shaw, Honey, & Butterworth, 1998).

The smart strategy of involving family systems in the intervention of substance-abusing members also should be multifaceted. First and foremost, families and members contribute by reducing their codependence and taking good care of themselves, regardless of what happens to their family member who is abusing substances. Some of this work will occur within family therapy, and some will take place through other activities such as meditation or pursuing personal goals for growth or achievement. Support, collaboration, and encouragement among all family members will help everyone. Also, family and individual goals will be met best if people refrain from destructive communications such as angry name calling, shaming, or ridicule. "Safety first" sets the foundation for moving towards actualization.

A lifestyle emphasizing purpose, moderation, cooperation, and wellness will go far to help all family members and the system itself. Perhaps it is trite to say "eat a healthy diet, follow nutritional guidelines, exercise regularly, and sleep eight hours a night," but few of us live everyday lives that reflect optimal wellness. Depression, which is an integral dynamic that significantly reduces the quality of life, also should be addressed for many families and individuals. As Gordon (1985) asserts in *When Living Hurts*, if depression is deep or chronic, people should be encouraged to get professional and peer help to minimize the pain. Finally, I advise persons to emphasize empowerment in their communications and relationships, and to be flexible and patient in a lifelong journey of pursuing healthy lives.

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Families Affected by Substance Abuse

William English

Rationale

Substance abuse (SA) extracts a very high toll on families. Functional families often lose vitality as they experience crisis, trauma, and post-traumatic stress. Troubled families usually need treatment, especially where there is co-dependency and enabling. Coping families can make many valuable contributions to support and encourage all members, including individuals with substance abuse.

Overview

This lesson defines the family, substance abuse, and the family life cycle. It describes the many influences that SA has on families, impact on children, effects on adult children, and cultural influences. Prevention and Intervention to heal substance abusers and their families emphasize systems theory and various types of family therapy. Explaining major obstacles to coping with SA and best practices in intervention helps students to be prepared to assess, guide, and counsel persons with SA.

Objectives

1. To increase awareness of key definitions—substance abuse, family, and family life cycle—to use in preventing SA and reducing the negative consequences of SA.
2. To increase understanding of the substantial negative influence(s) that SA typically has on families and children.
3. To increase awareness of general systems theory, the family therapy process, and the main types of family therapies, to balance families and cope with SA.
4. To increase understanding of co-dependency and other major obstacles that must be dealt with to empower families to be more functional.
5. To increase understanding of multiple interventions that represent best practices in assisting family systems and relatives of substance abusers.

Activities

The following exercises will personalize learning related to understanding SA and prepare students to intervene to balance SA families and SA individuals. Each exercise connects with one of the four objectives to this lesson.

Exercise I for Objective 1: Key Definitions

Divide students into small groups of two to six.

1. Request students talk about their own family systems in terms of type (dual career, single parent, or blended), style (open or closed), and the family's current place in the family life cycle.
2. Request that students also talk about their extended family systems and conjugal families, in terms of their behavioral patterns on a substance abstinence to substance addiction continuum. Share any efforts to intervene or cope with SA and the outcome.
3. Follow the self-disclosure of family systems and substance use with a guided discussion based on questions like:
   - Is it difficult to share this information with others? Why?
   - Why do we perceive this information as private?
   - What changes do you believe would strengthen your family and its members?
4. Facilitate a large group debriefing of the small-group activities, completed in activities one to three.

Exercise II for Objective 2: Influence of SA on Families

Divide students into smaller groups of eight to ten.

1. Request that students share personal knowledge of the effects of SA on a family system (their own, or some other family) that they know well.
2. Request that students also share perceptions of the impact of SA on children and on adult children of substance abusers. Discuss adults of substance-abusing parents in terms of being too dependent, anti-dependent, needless, and wantless. Discuss the payoffs, dynamics, and consequences of SA for dependent abusers and co-dependent relatives.
3. Conduct a "psychodrama" where students simulate a dysfunctional family group attempting to do problem solving. Decide on the problem (e.g., substance abuse, communication, or a major event like a move to a new state or town, teen pregnancy, etc.). Assume specific, stilted roles of the scapegoat (i.e., SA), enabler, lost child, hero, and mascot. One group member should be the director and facilitator of the psychodrama. Remaining group members are observers and should facilitate the debriefing of this activity.
4. As a total group, discuss what students learned from the self-disclosure period and psychodrama.

Exercise III for Objective 3: Theories and Approaches to Family Intervention

1. Facilitate a discussion about the rationale for a systems approach, the family process, and stages in family counseling.
2. Facilitate further discussion on the desired outcome goals, which will improve the functioning of family systems and individual family members.
3. Divide learners into groups of eight to ten and have each group choose to simulate a different type of family counseling approach (e.g., psychodynamic, humanistic, Bowenian, structured, communicational, or behavioral). Use specific therapy methods in the simulation.
4. Have each group simulate a specific type of family therapy group, where members enact roles of scapegoat, enabler, hero, lost child, mascot, and therapist/facilitator. Assume the mother is a cocaine abuser with an enmeshed communication style and that the father abuses alcohol and marijuana, and has a detached communication style. Assume that one of the children is "too dependent." Observers should take notes and guide a debriefing period after the therapy enactment.
5. Facilitate a large-group debriefing of the small-group activities, completed in activities one to three.

Exercise IV for Objective 4: Obstacles to Coping with SA

1. Have the entire group discuss the barrier of co-dependence. Consider intra personal and cultural factors that may contribute to co-dependence, especially the enabling. How have more coping families eliminated or reduced their co-dependency?
2. Divide the students into smaller discussion groups of about six. Have each group self-disclose obstacles that they have observed in families coping with SA: co-dependence, irrational fears, close approaches, low self-efficacy, weak social support, inadequate social skills, unresolved conflicts, stress and anger, non-mainstream culture, and dual diagnosis.
3. Require that each group work cn resolving a specific obstacle like a closed family system, low self-efficacy, poor social skills,and weak social support. Identify attitudes, techniques, and activities to cope with this obstacle and specify the measurable outcomes that will connote success.
4. Have each small group prepare an obstacle resolution report (ORR).
5. Have groups present their obstacle resolution reports to the whole group and get feedback and other ideas.
6. Conclude by debriefing the exercise with the whole group.

Exercise V: Best Practices in Working with Families

1. Make a summary overview about working with families affected by SA. Emphasize that SA is a

bicultural condition that significantly impacts on abusers, family systems, and individuals. Underscore that effective intervention needs to be multifaceted, intergenerational, and aimed at improving the function or wellness of family systems, family members, and substance abusers.

2. Identify subcultures that are especially at risk in terms of substance abuse (e.g., Native Americans, Mexican Americans, African Americans, Irish, soccer moms, teenagers, persons with disabilities or chronic illnesses). Use a visual aide (e.g., overhead or chalkboard) to record the results of this brainstorm.
3. Divide students into groups of six to discuss the issue of SA in-depth, as it applies to a particularly high-risk group. Let persons volunteer for their preferred problem resolution group. Consider cultural values, roles, and customs that should be respected.
4. Have each group prepare a Family Intervention Plan (FIP) that is tailored to helping families and individuals who are affected by subcultures to better cope with SA. Include specifying measurable outcomes of success.
5. Have groups present the FIP to the whole group, and get feedback and other ideas.
6. Conclude by debriefing the exercise with the whole group.